

# **Improving the U.S. Health Care System**

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Gandalf's Gang

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## Improving the U.S. Health Care System

Author Thomas S. Monson reminds us: “When performance is measured, performance improves.”(Favorite Quotations from the Collection of Thomas S. Monson, Deseret Books, 1985). This adage has applications in virtually all fields and has found its way into health care. Unfortunately, the measuring of health care quality is more difficult than measuring quality of other industries.

The earliest method used to compare health care systems was “benchmarking,” that is, measuring a hospital’s admission and length of stay. Other traditional measures of health care quality fall into three categories: structure, process, and outcome. Structure is a measurement of the capacities of a health care’s system and includes both facilities and health care providers. Process measures the interaction between providers and patients and includes utilization information. Outcome measures changes in patient’s health status as a result of being in the system and includes common tools like mortality rates, co-morbidity, patient satisfaction, and access. Patient satisfaction has been touted as the “best” measure. Peer review sessions, Performance Improvement Committees, and JCAHO (to name a few) are all modern instruments of measuring performance and are designed thereby to improving performance. As one might expect, there are advantages and disadvantages to each.

The World Health Organization (WHO) uses a different set of criteria for measuring the quality of health care systems around the world, specifically by evaluating how a country’s health care system meets three goals: the provision of good health, responsiveness to the expectations of the population, and the financial fairness. The U.S. ranked poorly in all but the ‘responsiveness’ category of a WHO’s recent report (World Health Report, 2000). Is this a fair assessment of our health care system? Although there is certainly room for improvement (such as reducing per capita spending, decreasing bureaucracy, and insuring the number of uninsured), comparing socialistic health care systems and values with a capitalistic system and its values is not only difficult, but also perhaps even inequitable.

Better measures of the “health” of the U.S. health care system may be found in the reports issued by the Institute of Medicine (IOM). In 1998, the IOM reported that our health care system must focus on six key areas in four levels of the health care system in order to raise the quality of the total health system. The six key areas, with a brief explanation, follow:

**Safety:** avoiding injuries to patients from the care intended to help them

**Effectiveness:** providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (in other words avoiding under use and overuse)

**Patient centeredness:** providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions

**Timeliness:** reducing waits and sometimes-harmful delays for both those who receive and those who give care

**Efficiency:** avoiding waste, in particular waste of equipment, supplies and energy

**Equity:** providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location and socio-economic status

This paper will briefly discuss approaches to making change in effectiveness and patient safety as a means of improving the health care system. Several of the approaches may be applied across more than one of the six key areas but the discussion will be limited to how these approaches might affect the two key areas of interest.

## **Effectiveness**

Three approaches to improving effectiveness include: use of clinical practice guidelines, disease management, and open access.

Clinical Practice Guidelines or CPGs are templates or practice protocols that guide clinicians in the diagnoses, treatment, and management of certain common medical conditions. When the CPGs are developed with multi-specialty consensus using evidence-based medicine and updated periodically, they can improve effectiveness by standardizing medical decisions. This is achieved by consolidating the best and most appropriate treatments for patients into an easy-to-access-and-follow resource.

Disease management or health care management is a concept designed to manage the long-term health of patients in a comprehensive manner. A variation of this theme, called case management, is used to manage complex patients. A team approach is used with usually a nurse as the captain to coordinate, organize, and facilitate communication between the multiple components typically used to treat patients within a health care system. The components include various medical specialists, physical therapy, pharmacy, lab, social services and education specialists just to name a few.

Open access is a system of patient scheduling with application mainly in outpatient clinics. The main tenet of the system is “doing today’s work today.” In a nutshell, patients are seen the day they call for appointments. Scheduling appointments for a future date is discouraged. This system improves effectiveness by forcing each component of a micro system i.e. reception, medical records, nurses, doctors, lab, radiology, pharmacy and insurance personnel to work quickly and efficiently to provide care for all that required it that day. Those with experience working with this system report lower “no show” rates, which also is a reflection of the effectiveness of the health care system.

## Safety

In addition to moves toward effective care, the IOM report placed great emphasis on the concern of improving safety practices. There are four crucial concepts the IOM addressed to improve safety in our health care delivery systems. The first is to acknowledge that the problem of accidental injury in the medical care delivery system is a serious one that needs to be addressed. Second, that the cause of injury to patients is not careless people but faulty systems. Third, that we need to redesign our systems to improve patient safety, and fourth, patient safety must become a national priority. The following discussion will utilize the above four concepts to address both global and specific areas to improve safety.

The IOM challenged all parties to become involved. Some, including patients served, have gone so far as to suggest a national organization be implemented for oversight of safety in the health care system. Controversy exists as to the extent of the problem as many physicians have voiced concern that the IOM overstated the magnitude of the problem. However, the facts support that more people die each year from medical errors than from motor vehicle accidents. Overall, there is general agreement that action is needed to make health care safer. The greater challenge will be to get providers actively involved in a process they currently don't value. How can this be done?

### Priority One – Safety Culture

Creating a culture of safety similar to that achieved in industries that have succeeded in becoming safe (e.g., aviation and nuclear power) is paramount yet difficult. To begin with, the dynamic nature of health care makes it a more complex industry than any other. This complexity is compounded further in our litigious society. The tendency to assign blame to a specific individual persists, when in fact the error was due to a system failure. Fear of reporting errors has led to underreporting and attempts to cover up errors. Our recommendation is for institutions to be driven by policy that supports individuals by realizing that safety is much more than individual carelessness or inadequacy. To acknowledge that most errors result largely from the failures of systems runs counter to the traditional focus of medical training on individual performance. Yet this is exactly what is needed, a complete paradigm shift. Seeking *system* success instead of penalizing *individuals* is fundamental to sustained success. This attitude shift is truly the requisite foundation for the future of a safer health care industry.

Another suggestion to improve safety was to ensure more consistently that providers remain current with the field specific scientific advances through periodic re-examinations and re-licensing. The entry-level test would be updated to match the current practice and technology, and practicing providers would be periodically re-tested at the same standard imposed on recent graduates. This approach would protect the public better than the current system of initial licensing and then paying a fee every two to five years to remain licensed. Although many states require certain disciplines to show documented continuing education, this is not mandated throughout all states.

Due to the way our health care system evolved, decentralization appears to be a natural consequence. Rapid technological advances and specialization have contributed to the poor organization of our overall system. Military care exemplifies some of the problems. Medical records are lost within the organization, documentation of care provided outside the MTF does not make it into medical record, and/or records held by the patient who forgets to bring them to the encounter-- all lead to incomplete information. Providers being TDY, deployed, or PCSing decreases continuity and consequently new providers frequently see the same patient for the same problem. The bottom line result is that providers operate independently of each other, providing care based on incomplete information, medical history, services provided in other settings, or current medications prescribed. These processes waste resources, leave unaccountable gaps in coverage, result in loss of information, but also are unsafe. Recent advances in technology (especially information technology) can be used as a catalyst to streamlining patient information as long as all provider components are linked.

Formerly we discussed many issues with the HIPAA regulations; but as we move toward compliance, computer links among all parties is inevitable. Capitalization on these advances could result in improved patient safety from a number of avenues. Patient information will literally be at the provider's fingertips. As medical records become computerized, we hope that much of the "lost information" will be captured. Complete patient information alone would allow the provider to synthesize better patient plans. Lack of legibility of medical orders has been cited as contributing to a large percentage of medication errors. Having electronic order entry has been shown to significantly decrease these errors. Enacted on national basis, electronic order entry could have a profound effect in the reduction in medication errors. Linking both providers and pharmacists to complete patient medication information will greatly improve their ability detect potential adverse drug interactions before they occur.

## **Conclusion**

Much of the emphasis on quality improvement emphasis has been placed on effectiveness and safety by suggesting the incorporation of these practices into daily processes. This work is proactive in nature and involves careful thought and an upfront commitment of both personnel and financial resources. It is difficult to show the "comptrollers" of the health services assets that preventive programs are beneficial, because in many instances outcomes may be difficult to quantify. With targeted, gradual initiatives, if planned, implemented, and managed well, we can improve the quality of our health care delivery system as a whole. The challenge rests in how to make that shift from a reactive perspective to a proactive perspective. Ultimately, as we learn better how to quantify outcome, the key of continuing success will lie with invested stakeholders.